Wisconsin Department of Safety and Professional Services

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 261-7083
Phone #: **(608) 266-2112**
E-Mail: web@dsps.wi.gov
Website: http://dsps.wi.gov

BOARD OF NURSING

REGISTERED NURSE/LICENSED PRACTICAL NURSE LICENSURE BY ENDORSEMENT APPLICATION

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.
Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14)

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth
_____ _____ _____
month day year

Daytime Telephone Number
( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever been licensed in Wisconsin as a Registered Nurse/Licensed Practical Nurse? If yes, do not complete this application. For instructions on reinstating your Wisconsin license call the Renewal Office at (608) 266-0627. If your RN/LPN license has been expired for 5 or more years you will need to submit a re-registration application (Form #2460).

Nursing School: _____

School Address: _____
(City) (State)

Graduation or Completion of Program Date: _____ _____ _____
month day year

Type of Degree/Program: _____

State of Original Licensure: _____

What is your state of primary residence? "Primary state of residence" is defined as the state of a person's declared fixed permanent and principal home for legal purposes; domicile.

_____

If not Wisconsin, do you plan to move to Wisconsin and take up primary residence?

☐ **Yes** ☐ **No**

APPLICATION FEES
Make check payable to Department of Safety and Professional Services and attach to application.

Check box for type of license you are applying for:

☐ RN $ 82.00 Endorsement Fee
☐ LPN $ 82.00 Endorsement Fee

CHECK BOX FOR TEMPORARY PERMIT

☐ **$ 10.00** in addition to the above fee (non-renewable and *non-refundable*) provide a copy of current RN/LPN license

For Receipting Use Only

Wisconsin Department of Safety and Professional Services

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

1. Fee(s) attached to this completed 5 page application (DSPS Form #772).
2. Statement of Graduation or Completion from Nursing School (DSPS Form #259). **(U.S. graduates only. Please do not provide transcripts as transcripts do not contain the information we require.)** If you are applying for RN licensure by examination through completion of the Pre-MSN basic nursing requirements program, there is no guarantee that you will be eligible for a RN license in other states.
3. Verification of licensure (include active and inactive licenses). See below.*
4. Conviction and Pending Charges (DSPS Form #2252) (if applicable) and copies of malpractice suit(s) (if applicable). Submit copy of court documents of criminal complaint and judgment of conviction.
5. Statement of Foreign Nursing Education (DSPS Form #1006). (Foreign graduates only.)
6. CES report with TOEFL. (Foreign graduates only.) (See DSPS Form #675.)

IS NAME ON ALL DOCUMENTS THE SAME? IF NOT, SUBMIT COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.

PRACTICE: Account for all activities and practice starting **from the date of graduation** or the completion of the program to the present time. **Must include professional and non-professional activities. ALL dates and time must be accounted for. No more than a 3-month gap allowed.** Please include dates unemployed. Example: stayed home to raise children, worked in retail, etc.) (Attach additional sheets if necessary.)

EMPLOYER NAME	CAPACITY EMPLOYED (i.e. office staff, food service, RN, LPN, etc)	LOCATION OF EMPLOYMENT (List City & State)	DATES EMPLOYED (Month/Year Format) From - To

List all state(s) you currently practice in. _____

☐ I have not worked within the last 5 years and am requesting a limited license for the sole purpose of completing the clinical portions of a nurse refresher course.

I AM, OR HAVE BEEN, LICENSED IN THE FOLLOWING STATE(S) (Include all active and inactive states including the state you are endorsing from):

By Written Exam: _____

By Endorsement/Reciprocity: _____

* To obtain verification from another state board, you **must first** view the NURSYS web site at (*www.nursys.com)* to see if your verification can be processed through NURSYS. Please follow their instructions for online processing.

If the state in which you *currently have or ever held* a license as a registered nurse/licensed practical nurse **is not** one of the participating states which uses the NURSYS program, complete DSPS Form #741 (this form may be copied). You must first contact each state board prior to forwarding this form to see if a fee is required for this service. This completed DSPS Form #741 must be returned directly from the other state board to the Board of Nursing at P.O. Box 8935, Madison, WI 53708-8935. **Verifications received from the applicant will be rejected by the Board.**

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary.)

		YES	NO
1.	Do you **anticipate** taking the NCLEX in another state? **If yes, in which state and date:** _____	❑	❑
2.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	❑	❑
3.	Have you ever surrendered, resigned, cancelled or been denied a professional license or other license in Wisconsin or any other jurisdiction? **If yes, give details on an attached sheet, including the name of the profession and the agency.**	❑	❑
4.	Have you ever failed to pass any state board examination, province of Canada examination, or NCLEX? **If yes, give details on an attached sheet.**	❑	❑
5.	Has any licensing agency ever taken any disciplinary action against you, including but not limited to, any reprimand, suspension, probation, limitation, revocation? **If yes, attach a sheet providing details about the action, including the name of the licensing agency and date of action.**	❑	❑
6.	Is disciplinary action pending against you in any jurisdiction? **If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.**	❑	❑
7.	Do you have any felony or misdemeanor charges pending against you? **If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)**	❑	❑
8.	Have you ever been convicted of a misdemeanor or a felony? **If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.)**	❑	❑
9.	Are you incarcerated, on probation or on parole for any conviction? **If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.**	❑	❑
10.	Have any suits or claims ever been filed against you as a result of professional services? **If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.**	❑	❑
11.	Are you registered, certified, or licensed in any other profession(s)? **If yes, state what profession(s) and in what states(s).**	❑	❑
12.	Have you ever been registered, certified, or licensed under any other name(s)? **If yes, state name(s) credentialed under.**	❑	❑

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice as a registered nurse/licensed practical nurse" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned nursing judgments and to learn and keep abreast of nursing developments; and
2. The ability to communicate those judgments and nursing information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform nursing tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

		YES	NO
13.	Do you have a medical condition which in any way impairs or limits your ability to practice nursing with reasonable skill and safety? **If yes, please explain.**	❑	❑
14.	Does your use of chemical substance(s) in any way impair or limit your ability to practice nursing with reasonable skill and safety? **If yes, please explain.**	❑	❑
15.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? **If yes, please explain.**	❑	❑
16.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? **If yes, please explain.**	❑	❑
17.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **If yes, please explain.**	❑	❑
18.	Are you currently engaged in the illegal use of controlled dangerous substances?	❑	❑
19.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	❑	❑

CERTIFICATION OF LEGAL STATUS.

I declare under penalty of law that I am (check one):

_____ a citizen or national of the United States, or

_____ a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Wisconsin Department of Safety and Professional Services

ALL APPLICANTS MUST COMPLETE THIS SECTION

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.

_____ _____

Signature of Applicant Date

Wisconsin Department of Safety and Professional Services

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

_____

First Name **Middle Initial** **Last Name**

_____

Profession

Date of Birth _____ _____ _____
month day year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Children and Families for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

EMAIL ADDRESS:

Do you have an email address? ☐ **Yes** ☐ **No**

If yes, this field is required to receive your application status electronically. Your email address must be clearly legible with the correct case sensitive information.

EMAIL ADDRESS: Submit your email address in the spaces provided below or attach a printer copy.

If no, your checklist will be sent by first class mail.

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[1] Section 440.03 (11m), Wis. Stats.
[2] Sections 49.22, and 440.13, Wis. Stats.
[3] Section 440.12, Wis. Stats.
[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.